1881. *March* 29. The lad was readmitted, having suffered more, and lost flesh considerably. His temperature was very hectic. In April Mr. Barwell sounded through the persistent sinus, and detected a stone.

May 5. Leave for further procedure was obtained. The difficulties foreseen were from proximity of twelfth rib to the crest of the ilium, and from amount of dense cicatricial tissue. Patient, when etherized, was laid across a thick sand-bag, so as to bend spine forwards and to the right. Mr. B. made the usual oblique incision, but the scar-tissue so obscured parts he could not trust them as guides to the kidney. He followed the sinus with his finger, detected the stone, and, passing the knife along the digit, laid the gland bare, obtaining more room by running the scalpel along lower border of last rib. An attempt to remove the stone failed, but produced some bleeding, restrained by pressure, while he quickly enucleated the hard body enough to pass a silk ligature over it, and tie it near its calyx; bleeding being thus checked, the rest was more carefully peeled away, until he could feel the pedicle isolated and distinct. A second cord was passed in the same way in front of the kidney, and tied round the pedicle *en masse*. There was not room to remove the organ entire. He cut it in two with scissors in the depth of the wound, severed each portion from the tied stalk, and removed them separately.

The boy's temperature after the first night steadily improved. A good deal of albumen was in the urine at first; but regulation of diet has cured this condition. A piece of sloughed ureter 4½ inches long, with the ligatures attached, came away on the forty-sixth day.

June 22. The boy is well in health. Has gained flesh. Temperature normal. Only a minute wound remains.

Partial Excision of the Bladder.

Dr. ADOLPH FISCHER, of Buda Pesth, presented a paper on this subject at the London Congress, which embraced the results of some interesting experimental observations. In order to answer on the ground of practical experience the following questions, he has excised larger or smaller portions from the bladder of seven dogs.

1. Is it necessary in operating on dogs to take strict antiseptic precautions?
2. Is the operation attended by great dangers, and has the wound of the bladder, if properly stitched, a tendency to heal?
3. Which material, and which kind of suture is the most suitable?

Four of the seven dogs recovered.

The first two were operated upon antiseptically; one died. *Post-mortem.*—Sutures not accurate; peritonitis.

The second two not strictly antiseptically; one died on the third day with a high temperature. *Post-mortem.*—Hemorrhage into the peritoneal cavity.

Three dogs operated upon not antiseptically at all; one died. In the fatal case Dr. Fischer had excised a considerable part from the trigonum vesicæ. *Post-mortem.*—Gangrene of the bladder.

The material for sutures was Lister's antiseptic silk, silk boiled in five per cent. carbolic lotion, and catgut. Each of these materials answered well. Dr. Fischer used the interrupted and the combined suture, and a modification of my own, the combined interrupted suture.

From these experiments the following deductions may be drawn:—

1. In operating on dogs antiseptic precautions are not absolutely necessary.
2. Wounds in the bladder, which are afterwards carefully united by sutures, are not particularly dangerous.
3. Good results are principally dependent upon the accuracy of the suture.

There can be no doubt that this operation is more likely to be successful on the human subject, because it can be done antiseptically; the bladder can be subjected to a mechanical treatment (irrigation with antiseptic fluids); a catheter can be kept in the bladder, and absolute rest can be secured.

The indications for partial excision of the human bladder may be brought at present under the following heads:—

1. Traumatic injuries to the bladder with contused edges.
2. Diverticula of the bladder, containing encysted calculi.
3. General dilatation of the bladder, when the cause of the disease has either been removed or is removable.
4. Benign and malignant tumours involving the wall of the bladder.
5. Vesico-abdominal, vesico-vaginal, and recto-vesical fistula.
6. Destructive ulcerations threatening rupture, and withstanding other methods of treatment.

Treatment of Scrofulous Inflammation of Joints.

Prof. Hueter read a paper at the London Congress on this subject, of which the following is an abstract:—

1. Scrofulous inflammation of a joint is characterized by the formation of granulation tissue, so that suppuration follows,—while in other forms of joint inflammation, especially the traumatic form, suppuration precedes, this formation of granulation tissue.
2. Scrofulous inflammation can be described as leading to the formation of granulations, as a synovitis granulosa, if it proceeds from the synovial membrane; as a myelitis granulosa, if granulation masses are previously formed in the medullary substance of the bones (of the joint). In the latter case, the synovitis granulosa follows the myelitis granulosa.
3. In the scrofulous granulations, "noxæ" develop themselves, which, at the seat of the primary disease, lead to the formation of tubercles (local tuberculosis of joints), and by getting into the bloodvessels, produce general tuberculosis (lungs, and other organs).
4. This form of joint-inflammation may, therefore, be called the scrofulo-tubercular.
5. That form of joint-inflammation, which is produced by congenital syphilis, shows similar appearances; it must, nevertheless, be differentiated, both for diagnostic and prognostic purposes, since there are no "noxæ" which can lead to tuberculosis.
6. The early stage of scrofulous inflammation may be successfully treated by the injection of a 3–5 per cent. solution of carbolic acid. The injection must be made with a Pravaz syringe, in such a way that the solution comes in immediate contact with the granulation tissue, *i. e.*, with the interior of the joint, if the case is one of synovitis granulosa, and with the interior of the bone, if it be one of myelitis granulosa.
7. Antiphlogistic treatment of scrofulous joints (fixation, massage, compression, permanent extension, blood-letting, blistering), is of little or no value.
8. Incision into the joints, drainage, scraping away the granulations, or partial venesection of a joint, are to be discarded.
9. Carbolic injections having failed, excision is the best treatment, especially after suppuration has set in.

10 and 11. Excision should be total. When practised early, the results are the most satisfactory.